DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 2 8

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/00

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.160

7. FEDERAL BUDGET IMPACT:
a. FFY 2000-2001 $ _____
b. FFY 20001-2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A.1 Page 17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A.1 Page 17

10. SUBJECT OF AMENDMENT:
Inpatient Psychiatric Facility Services for Individuals under 21

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
H. David Bruton, MD

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 22, 2000

16. RETURN TO:
Office of the Secretary
Department of Health & Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 29, 2000

18. DATE APPROVED:
January 30, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

(c) The form approved for ICF placement is valid for 60 days. If a patient has not been placed during this period of validity, the state or its designated agency should be contacted. At this time, the reviewing nurse will re-evaluate the form and determine if more current information is needed.

15. Intermediate Care Facility Services

Limitations and prior approval same as described in Item 14.b.(3).

a. Intermediate Care Services Including Such Services in a Public Institution for the Mentally Retarded

Limitations and prior approval same as described in Item 14.b.(3).

16. Inpatient Psychiatric Facility Services for Individuals Under 21

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level of care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the recipient in an appropriate institution within the three day administrative time allowance.

Admissions for all out of state psychiatric hospitals including those enrolled as border psychiatric hospitals are subject to prior approval for necessity to go out of state. Services in out-of-state hospitals are provided only to the same extent and under the same conditions as medical services provided in North Carolina.